



AMERICA'S ESSENTIAL HOSPITALS

May 1, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Ave. SW
Washington, DC 20201

Ref: CMS-1788-P: Medicare Program; Medicare Disproportionate Share Hospital (DSH) Payments: Counting Certain Days Associated with Section 1115 Demonstrations in the Medicaid Fraction

Dear Administrator Brooks-LaSure:

Thank you for the opportunity to comment on the above-captioned proposed rule. America's Essential Hospitals appreciates the Centers for Medicare & Medicaid Services' (CMS') work to improve the delivery of high-quality, integrated health care across the continuum and close the existing health equity gap. We are concerned, however, that CMS' proposal to exclude certain Medicaid Section 1115 waiver days from the Medicare disproportionate share hospital (DSH) calculation would counteract these priorities and harm hospitals serving a safety net role. The proposal would result in substantially lower reimbursement for essential hospitals already facing financial and workforce challenges, further jeopardizing their ability to serve their marginalized communities and promote health equity.

America's Essential Hospitals is the leading champion for hospitals and health systems dedicated to high-quality care for all. Our more than 300 member hospitals fill a vital role in their communities. Their commitment to serving marginalized communities and low-income patients—the types of patients whose care the Medicare DSH statute was intended to support—is evident in their payer mix. Essential hospitals provide a disproportionate share of the nation's uncompensated care (UC), and three-quarters of their patients are uninsured or covered by Medicare or Medicaid. On average, an essential hospital provides more than \$60 million in UC annually, nearly eight times as much as other hospitals. While representing only 5 percent of all U.S. hospitals, essential hospitals provide 27.2 percent (\$7.4 billion) of all charity care nationwide.¹

Essential hospitals provide state-of-the-art, patient-centered care while operating on margins less than half that of other hospitals—3.2 percent on average compared with 7.7 percent for all

¹ Clark D, Ramiah K, Taylor, J, et al. *Essential Data: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2020 Annual Member Characteristics Survey*. America's Essential Hospitals. September 2022. <https://essentialdata.info>. Accessed April 5, 2023.

hospitals nationwide.² These narrow operating margins result in minimal reserves and low cash on hand—circumstances exacerbated by financial pressures related to COVID-19 and novel challenges as hospitals emerge from the pandemic, such as rising workforce costs and shortages, increasing supply costs, and supply shortages.

Essential hospitals' commitment to serving all people, regardless of income or insurance status, and their diverse patient mix pose unique challenges. A disproportionate number of their patients face sociodemographic challenges to accessing health care, including poverty, homelessness, language barriers, and low health literacy. More than seven million people in essential hospital communities have limited access to healthy food, and nearly 16 million live below the poverty line.³ Essential hospitals are uniquely situated to target these social determinants of health (SDOH) and are committed to serving these marginalized patients. These circumstances, however, compound our members' challenges and strain their resources, requiring flexibility to ensure essential hospitals are not unfairly disadvantaged for serving marginalized populations and can continue to provide vital services in their communities.

As essential hospitals, our members are committed to ending health disparities and providing high-quality care to all, including underrepresented and marginalized populations. Federal policy changes, such as Medicare payment cuts, disproportionately affect these hospitals, which already operate on financial margins narrower than the average hospital. Such policy changes also undermine Medicare beneficiaries' access to the linguistically and culturally competent care essential hospitals provide. The Affordable Care Act's (ACA's) reduction of aggregate DSH payments has led to drastic cuts to Medicare DSH payments, a critical funding source for essential hospitals. Further reducing Medicare DSH payments to hospitals in states that leverage Medicaid waivers to subsidize care for uninsured and underinsured patients would only further exacerbate their predicament.

We are encouraged that CMS has shifted course on its original proposals to exclude premium assistance waiver days from the Medicare DSH calculation. However, we are deeply concerned that the proposal to exclude UC pool days from the Medicare DSH calculation would have a disproportionately negative effect on essential hospitals. For the reasons we outline below, CMS' proposal to exclude UC pool days is contrary to the Medicare statute and would be a counterproductive policy. America's Essential Hospitals and other stakeholders previously have voiced these objections on record, leading CMS to withdraw similar proposals twice. We continue to express these same concerns, which are still as germane as when CMS first proposed this policy in 2021. **We urge CMS to once and for all withdraw this detrimental proposal to exclude UC pool days from the Medicare DSH calculation.**

- 1. CMS should finalize, with clarification, its proposal to include Medicaid Section 1115 waiver days associated with premium assistance programs.**

To determine if a hospital is eligible to receive DSH payments, CMS uses a hospital's disproportionate patient percentage (DPP), which is the sum of two fractions—a Medicare fraction and a Medicaid fraction. CMS then uses the DPP to calculate a DSH adjustment percentage, which determines the amount of empirically justified DSH payments a hospital will receive as an add-on to payments under the Inpatient Prospective Payment System (IPPS). The Medicaid fraction of the DPP is calculated using the hospital's number of patient days for patients who were eligible for medical assistance under Title XIX of the Social Security Act (the

² Ibid.

³ Ibid.

title of the Act pertaining to Medicaid) but not entitled to Medicare Part A benefits, divided by the hospital's total patient days. The statutory language describing the Medicaid fraction states that, in addition to including these Medicaid-eligible days, CMS may include days of patients who are not directly eligible for Medicaid benefits but who receive benefits through a demonstration project approved under a Section 1115 waiver.⁴

We are pleased that CMS has decided to include in the Medicaid fraction days for patients receiving premium assistance through Section 1115 waivers, which CMS had previously proposed to exclude altogether or to limit substantially. CMS proposes to include days associated with patients who “purchase health insurance with the use of premium assistance provided by a Section 1115 demonstration, where State expenditures to provide the insurance or premium assistance may be matched with funds from title XIX.”⁵ CMS proposes further that the premium assistance must cover 100 percent of the premium to buy insurance that covers inpatient hospital coverage. CMS indicates this change would include waiver days in all seven states with existing Section 1115 premium assistance waivers. Some of these states use premium assistance waivers to cover newly eligible Medicaid expansion populations, while others use premium assistance waivers to cover the cost-sharing of individuals with employer-sponsored insurance. These waivers are key policy levers to expand coverage for low-income patients and to reduce their medical costs. Therefore, we support CMS' inclusion of these days in the Medicare DSH calculation.

We encourage CMS to clarify its proposal to include all waiver days in all states that have leveraged Section 1115 waivers to create premium assistance programs. To confirm qualification under CMS' 100 percent threshold, hospitals would need to conduct an assessment to determine whether the policy would cover premium assistance programs in their state, resulting in uncertainty about whether certain days can or cannot be included in the Medicaid fraction. For example, the list of seven states CMS provides does not mention Connecticut, which recently received approval for a premium assistance program that pays through the health insurance exchange to cover low-income individuals ineligible for Medicaid. The Connecticut program covers 100 percent of insurance costs, which includes coverage for inpatient hospital services, and therefore should qualify under CMS' proposal. **We ask CMS to clarify that days related to Connecticut's Section 1115 premium assistance waiver would be included and to revise its policy to remove the 100 percent premium coverage requirement, which is unnecessary and is complicated to administer.** CMS concedes that states with premium assistance waivers all qualify for the 100 percent requirement, so this requirement is unnecessary and generates confusion about which states' premium assistance waivers would qualify under CMS' proposal.

2. CMS' proposal to exclude Section 1115 UC pool days from the DSH calculation is contrary to the Medicare statute.

CMS should withdraw its proposal to exclude patient days related to UC pools and other types of funding pools authorized by Section 1115 waivers because it is contrary to the Medicare statute. In the rule, CMS for the third time proposes to amend the Medicare DSH regulations to exclude from the Medicaid fraction days of patients whose health care costs are covered by UC pools. CMS maintains that, since 2004, it has never been its policy or intention to include UC pool days in the Medicaid fraction and that it has intended to limit the types of Section 1115 waiver days that can be counted in the Medicaid fraction to days

⁴ Social Security Act § 1886(d)(5)(F)(vi)(II).

⁵ 88 Fed Reg. 12623, 12629.

for which individuals are eligible to receive inpatient hospital insurance benefits under a demonstration project. However, due to several federal court decisions from 2018 to 2020 invalidating CMS' interpretation of the Medicare statute, CMS is attempting to rewrite the regulations to preclude hospitals explicitly from counting UC pool days in their Medicaid fractions.

According to the Medicare statute, in calculating the Medicaid fraction, CMS must first include all days for patients eligible for medical assistance under the state plan. The statute then states that, in determining the number of Medicaid-eligible days, the "Secretary may, to the extent and for the period the Secretary determines appropriate, include patient days of patients not so eligible but who are regarded as such because they receive benefits under a demonstration project approved under title XI."⁶ That is, CMS may regard Section 1115 waiver days as Medicaid-eligible and, therefore, include them in the Medicaid fraction. At issue is CMS' interpretation of the statute's language that CMS "may...regard" Section 1115 waiver days as Medicaid-eligible. CMS interprets this language to give it unfettered discretion to determine which waiver days are included and excluded from the Medicaid fraction. However, as we explain below, this interpretation is at odds with the Medicare statute, a point that federal courts have emphasized.

As various federal courts have held, CMS' interpretation of the Medicare statute (and not just its 2004 regulation) is flawed, and Section 1115 waiver days associated with UC pools must be included in the Medicaid fraction. CMS' proposal to distinguish between different types of waiver days is contrary to the Medicare statute. Once CMS approves a Section 1115 waiver, the days associated with that waiver must be included in the Medicaid fraction. As noted by the U.S. Court of Appeals for the Fifth Circuit in *Forrest General Hospital v. Azar*, "If patients underlying a given day were Medicaid-eligible or 'receive[d] benefits under a demonstration project,' then that day goes into the numerator. Period."⁷ The court held that the statute is unambiguous that "patients who aren't actually Medicaid-eligible still count towards the Medicaid fraction's numerator if they're considered or accounted to be capable of receiving a demonstration project's helpful or useful effects by reason of a demonstration project's authority."⁸

CMS cites the statutory language saying that the Secretary "may," to the extent the Secretary deems fit, regard days as Medicaid-eligible as giving it authority to exclude UC pool days in the six states in question. When CMS approves a state's Section 1115 demonstration, it has already used its discretion to regard the patients that receive benefits through the demonstration project as Medicaid-eligible; thus, they must be included in the Medicaid fraction. CMS cannot retroactively change that determination. As a federal district court noted in another case, in which the court struck down CMS' policy to exclude UC pool days associated with Florida's Low Income Pool, the discretion to determine which days are included or excluded in the Medicaid fraction is a prospective exercise: "But such discretion must be exercised 'prospectively,' not after a demonstration project has already been fully approved and implemented and the bill comes due."⁹ And, as the court in *Forrest General* noted, "once the Secretary authorizes a demonstration project, no take-backs. The statutory discretion isn't discretion to exclude populations that the Secretary has already authorized and approved for a given period; it's discretion to authorize the inclusion of those populations in the first place."¹⁰ This case law

⁶ Social Security Act § 1886(d)(5)(F)(vi)(II).

⁷ *Forrest General Hospital v. Azar*, 926 F.3d 221, 229–230 (5th Cir. 2019).

⁸ *Forrest General Hospital v. Azar*, 926 F.3d 221, 230 (5th Cir. 2019).

⁹ *Bethesda Health, Inc. v. Azar*, 389 F. Supp. 3d 32, 53–54. (D.D.C. 2019).

¹⁰ *Forrest General Hospital v. Azar*, 926 F.3d 221, 233 (5th Cir. 2019).

makes clear that, under the Medicare statute, CMS must include UC pool days related to already-approved Section 1115 waivers in the Medicaid fraction of the DPP because they have already been regarded as eligible.

CMS also attempts to compare Section 1115 UC pool payments to Medicaid DSH payments, which are payments to hospitals for treating uninsured, underinsured, and low-income patients. CMS cites cases ruling that patients whose care costs are indirectly offset by Medicaid DSH payments cannot be included in the Medicaid fraction as justification for its proposal to exclude UC pool days. However, the reasoning on which the courts relied in the Medicaid DSH cases that CMS cites is distinguishable from the issue of Section 1115 waiver days. In the Medicaid DSH cases, the question was whether Medicaid DSH days for uninsured patients—who were, by definition, ineligible for Medicaid—were nonetheless considered Medicaid-eligible under the first part of the language in the provision in question—that is, whether the patients were eligible for medical assistance under Title XIX under the state plan. Those cases did not deal with the Secretary’s interpretation of the “regarded as such” language related to Section 1115 waivers, which is the statutory language that requires CMS to include UC pool days.

Finally, the proposal is contrary to congressional intent for the Medicare DSH program, which was designed to support hospitals treating low-income patients. In creating the Medicare DSH program in 1986, Congress recognized that hospitals treating low-income patients incur higher costs generally and have higher Medicare costs. This is clearly expressed in the statutory language for traditional (pre-ACA) DSH payments, which states that CMS shall provide additional payments for IPPS hospitals that serve “a significantly disproportionate number of low-income patients.”¹¹ By excluding UC pool days, CMS ultimately reduces DSH payments to these hospitals treating low-income patients with funds provided by these UC pools, which is contrary to the DSH statute’s purpose to support hospitals treating low-income patients.

3. CMS’ proposal to exclude UC pool days from the Medicaid fraction would harm essential hospitals in states with UC pools, be detrimental to their health equity efforts, and ultimately harm hospitals in all states.

Setting aside the legal deficiencies of CMS’ proposal to exclude UC pool days, the proposal is also a flawed policy that would be detrimental not just to essential hospitals in the six directly affected states but ultimately to hospitals nationwide. Therefore, even if CMS were correct in its belief that the statutory language allows it to decide retrospectively which waiver days to include in the Medicaid fraction, CMS should exercise this discretion to include UC pool days. Many states use UC pools to cover the cost of numerous services (including inpatient hospital services) for uninsured and underinsured individuals, including low-income patients covered by hospitals’ charity care policies. Section 1115 waivers grant states the ability to test new approaches to expanding coverage and paying for services that don’t fall within the usual requirements of the Medicaid statute. These waivers offer states the flexibility to determine which interventions are best for their populations. Excluding UC pool waiver days (which CMS has approved) from the Medicaid fraction would effectively penalize hospitals in states that have chosen specific types of arrangements to extend coverage or reimburse for health care services to low-income populations through Section 1115 waivers in a manner that CMS has deemed to “promot[e] the objectives of” the Medicaid program.¹²

¹¹ Social Security Act § 1886(d)(5)(F)(i)(I).

¹² Social Security Act §1115.

CMS estimates the annualized impact across the six states could be \$349 million and possibly up to \$436 million in reduced Medicare DSH payments to hospitals in six states. A proposal of this magnitude would disproportionately harm essential hospitals, which operate on narrow and often negative margins. This policy would affect not only the hospitals but ultimately the low-income patients that seek care at these hospitals, including low-income Medicare beneficiaries. Essential hospitals are chronically underfunded, due to their lower share of commercially insured patients relative to other hospitals, their high level of uninsured patients and patients insured by public payers, the disproportionately high amount of uncompensated care they provide, and the volatility of the disparate payment sources on which they rely. CMS' proposal will result in cuts to Medicare DSH payments that compound existing double-digit percentage reductions from the ACA. In 2023, total DSH payments are projected to be \$10.36 billion, representing a 26 percent cut compared with the amount of DSH CMS would have distributed under the pre-ACA methodology. These cuts to DSH payments are detrimental and unjustifiable for essential hospitals.

Apart from the obvious financial effect on essential hospitals, excluding UC pool days will impede hospital efforts to eliminate health disparities and promote health equity. The administration has prioritized the importance of tackling structural racism and promoting equity throughout the federal government.¹³ Essential hospitals are at the center of the health care safety net—by virtue of their very mission and diverse communities, they are experts in targeting SDOH and advancing health equity. This expertise stems from their firsthand experience witnessing and tackling the effects of structural racism and how it routinely disadvantages and produces cumulative and chronic adverse outcomes for people of color, who made up more than half of member discharges in 2020.¹⁴ SDOH negatively affect the health, well-being, and quality of life of essential hospital patients. The cuts resulting from CMS' proposal would jeopardize the sustainability of essential hospitals' programs to provide culturally competent care to their marginalized patients.

Beyond the hospitals in the six directly affected states, CMS' proposal ultimately would reduce DSH payments to hospitals nationwide. Thus, the scope of the effect would be broader than CMS indicates in the rule. Under the ACA's revised Medicare DSH methodology, DSH payments now are made as two separate payments—the empirically justified amount (25 percent of traditional DSH payments) and UC-based DSH payments. UC-based DSH payments are distributed from a fixed pool of funds, which CMS determines by first estimating what 75 percent of aggregate traditional DSH payments would have been each year. CMS then adjusts this amount based on changes in the uninsured rate to yield the final pool of funds from which the agency distributes UC-based DSH payments.

Because the amount available for UC-based DSH funds depends on how much CMS would have distributed using the traditional methodology, a decrease in those traditional DSH payments resulting from the exclusion of certain Section 1115 waiver days will result in a smaller pool of UC-based DSH funds available to all DSH hospitals. This will harm all hospitals, including those hospitals in states without Section 1115 waiver-based UC pools. In the rule, CMS justifies its proposal by saying that “counting all low-income patients in States with uncompensated/undercompensated care pools could drastically and unfairly increase DSH payments to hospitals located in States with broad uncompensated/undercompensated care

¹³ Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government, E.O. 13985 (2021).

¹⁴ Clark D, Ramiah K, Taylor, J, et al. *Essential Data: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2020 Annual Member Characteristics Survey*. America's Essential Hospitals. September 2022. <https://essentialdata.info>. Accessed April 5, 2023.

pools in comparison to hospitals in States without uncompensated/undercompensated care pools.” Yet, CMS’ proposal would serve only to decrease DSH payments to hospitals in both states with UC pools and states without UC pools.

The ramifications of CMS’ proposal could extend beyond Medicare and affect hospitals’ eligibility for the 340B Drug Pricing Program, which would further jeopardize access to care for marginalized communities and hospitals’ health equity initiatives. Decreases in the DPP resulting from CMS’ proposal could result in some hospitals losing eligibility for the 340B program, which is determined using the DSH adjustment percentage (derived from the DPP). A loss in 340B eligibility would undermine these safety net hospitals and their efforts to expand access to their marginalized communities.

Therefore, the effect of CMS’ policy would resonate across all hospitals nationwide and undermine those hospitals serving low-income patients. **For these reasons, we urge CMS to withdraw its proposal and to instead include these Section 1115 waiver days in the Medicare DSH calculation.**

America’s Essential Hospitals appreciates the opportunity to submit these comments. If you have questions, please contact Senior Director of Policy Erin O’Malley at 202-585-0127 or eomalley@essentialhospitals.org.

Sincerely,

Bruce Siegel, MD, MPH
President and CEO